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and annual aortic growth rates were calculated. The false lumen on all final CTA scans was classified as either a patent false lumen, or a (partially) thrombosed false lumen. All dissections were categorized as spiral or straight dissections and the growth and thrombosis rate of these dissections were compared.

Results: Forty patients were included (28 male; mean age 59 ± 11 years), of whom 16 presented with a spiral and 24 with a straight dissection. The mean annual diameter growth in patients with a spiral dissection was 3.9 ± 6.5 mm and significantly higher than in straight dissections (2.0 ± 7.7 mm; $p = 0.043$). There were 5 patients with a spiral dissection and a (partially) thrombosed false lumen, and 17 with a straight dissection and a (partially) thrombosed false lumen. There was a significant difference between the thrombosis rate of patients with a spiral and straight dissection ($p = 0.014$).

Conclusions: The aortic growth rate is higher in patients with a spiral type B dissection when compared to those presenting with a straight dissection. The false lumen is less likely to thrombose in patients with a spiral type B dissection. It is advisable to monitor patients with a spiral type B dissection more closely during FU, as aorta-related adverse events are probably more likely to occur.

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PS32.

TEVAR for Aneurysmal Degeneration of Chronic Descending Thoracic Aortic Dissections

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Objectives: Examine the results of thoracic endovascular aneurysm repair (TEVAR) for chronic descending thoracic aortic (DTA) dissections with aneurysmal degeneration.

Methods: Over 70 months at a single institution, 27 patients underwent TEVAR for aneurysms related to chronic (> 6 weeks) DTA dissections.

Results: Patient age was 68 ± 10 years; 67% were male. Indications for repair were aneurysm size (mean 6.1 ± 1.1 cm), growth, or pain; 1 patient was ruptured. Nine (33%) patients had undergone prior open repair of Debakey I dissections. Eight (30%) patients had Debakey IIIA dissections, 9 (33%) had IIIB dissections, and 1 (ruptured) had unknown extent. The left subclavian artery was covered in 14 (52%) patients, 9 of whom underwent prophylactic revascularization. Preoperative false lumen (FL) status was patent in 18 (67%), partially thrombosed in 5 (19%), thrombosed in 3 (11%), and unknown in 1 patient. On completion angiogram, no patient had perfusion of the proximal FL; 9 had perfusion of the distal FL. One patient had planned fem-fem bypass to revascularize a leg arising from the FL. There were 2 perioperative complications: 1 patient sustained paraparesis that resolved, and 1 patient suffered an access injury. Thirty-day mortality was 4% (1/27); the one death was in the ruptured patient. Of the 23 surviving patients with patent or partially thrombosed FL preoperatively, 18 (78%) had thrombosis of the aneurysmal FL, 4 (17%) had continued perfusion of the aneurysmal FL (one underwent repeat endovascular intervention), and 1 (4%) had no radiologic follow-up. In patients repaired electively, 3-year Kaplan-Meier survival was 89% ± 8%. In patients with partially thrombosed FL preoperatively, 3-year survival was 100%.

Conclusions: TEVAR for aneurysms due to chronic dissections of the DTA can be performed with acceptable short and intermediate outcomes, and may be of particular benefit in patients presenting with partially thrombosed FL.

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PS34.

Comparing Open and Endovascular Repair of Abdominal Aortic Aneurysm Accounting for Clinical Judgment

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Objectives: Surgeons' judgments of risk and benefit are linked to their choice of a specific operation, making comparison of effectiveness difficult. Using variables thought to drive such judgment, we developed a regression model to stratify the likelihood that any patient would receive endovascular (EVR) vs open repair (OAR) for AAA and analyzed outcomes for each likelihood quintile separately.

Methods: 137,300 patients age≥65 with elective AAA repair in 2002-06 were identified from Medicare inpatient files. Using these claims data, our model divides the population into 5 quintiles of 27,460 patients based on likelihood of receiving EVAR, which was 87% for Q1, 75%, 48%, 24%, &12% for Q5. For each quintile, we compared outcomes (30-day mortality, conversion to OAR & 5-year survival), and patient characteristics using Kaplan-Meier analysis, Cox regression, & chi-square test.

Results: Comparing Q1 to Q5, surgeons used EVR more on men (38 vs 13%), older patients (age 77 vs 74, octogenarians 36 vs 13%), with more coronary artery disease (58 vs 45%) & diabetes (19 vs 10%), and less CHF (14 vs 19%), leg ischemia (2 vs 7%), & emphysema (35 vs 48%).